POLICY AND COMMUNICATIONS BULLETIN
THE CLINICAL CENTER

Medical Administrative Series

M91-7 (rev.) 5 May 1998

MANUAL TRANSMITTAL SHEET

SUBJECT: Do Not Resuscitate (DNR) Orders
and Limited Treatment Orders

1. Explanation of Material Transmitted: This issuance transmits the revised policy of the Medical Executive Committee regarding situations in which it may be considered appropriate not to provide cardiopulmonary resuscitation, and introduces the phrase "limited treatment order" to clarify and honor patient preferences regarding emergency and end of life care. Explicit limited treatment orders should help prevent the ambiguous and potentially dangerous practice of "partial" or "limited" codes. The draft also outlines a more detailed procedure for addressing disagreements between the health care team and the patient or surrogate. The revised policy was approved by the Medical Executive Committee at its meeting on 5 May 1998.

2. Material Superseded: MAS No. 91-7, dated 1 November 1991

3. Filing Instructions: "Other" Section

   Remove: No. 91-7, dated 1 November 1991

   Insert: No. M91-7 (rev.), dated 5 May 1998

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M91-7 (rev.) 5 May 1998

SUBJECT: Do Not Resuscitate (DNR) Orders
and Limited Treatment Orders

PURPOSE

To ensure that DNR and Limited Treatment Order decisions are discussed, documented, and carried out in a medically responsible and consistent manner that respects patient autonomy and promotes the patient's best interests.

POLICY

A. Definitions

1. DNR (Do Not Resuscitate) order: An explicit order not to attempt cardiopulmonary resuscitation (CPR) in the event of a cardiopulmonary arrest. A DNR order is applicable only after cessation of effective cardiac or respiratory function. A DNR order does not limit or restrict the use of any intervention prior to cardiopulmonary arrest.

2. Limited Treatment order: An order that explicitly prevents the use of a specified, life-sustaining intervention, such as blood transfusion, intubation or the administration of vasopressors prior to the occurrence of a cardiopulmonary arrest.

3. Decision-making capacity: the ability to comprehend information relevant to a decision, deliberate about choices in accord with personal values and goals, and communicate such choices to caregivers.

B. General Statements

1. It is the policy at the Warren G. Magnuson Clinical Center (CC) of the National Institutes of Health to initiate CPR for any patient who suffers an acute cardiac or respiratory arrest in the absence of a DNR order.

2. There are circumstances when it is medically, legally, and ethically appropriate not to provide CPR, and then, an order to not attempt resuscitation (DNR) may be indicated.

3. Any adult with decision-making capacity may choose to refuse any treatment, including cardiopulmonary resuscitation (CPR), even if the patient is not terminally ill.

4. DNR and Limited Treatment decisions made by legal guardians or surrogates for patients without decision-making capacity should be based on their knowledge of the patient's preferences as expressed in explicit conversations or preferably in a written advance directive. When the patient's preferences are not known, these decisions can be made by applying the standard of the patient's best interests.

5. The CC Code Team must be activated for all cardiopulmonary arrests that occur in the absence of a DNR order, other than those in the intensive care units (ICUs) and operating rooms.

6. When activated, the Code Team will manage the patient according to American Heart Association Guidelines. Limited Treatment orders to conduct "partial codes" or "limited codes" that deviate from Advanced Cardiac Life Support (ACLS) guidelines are not permitted because they are ambiguous and may lead to unintended and undesirable outcomes such as anoxic brain injury in an otherwise successfully resuscitated patient.

7. Most Limited Treatment orders should be written only for patients with an active DNR order. Limited Treatment orders in the absence of a DNR order may lead to

inconsistent medical decisions and harm to the patient. A Limited Treatment order might preclude the early initiation of a more effective or less invasive intervention that could prevent the cardiopulmonary arrest. Further, certain Limited Treatment orders may make successful resuscitation unlikely or impossible.

8. At times, the goals of honoring patient preferences and providing appropriate medical care may best be served by writing a Limited Treatment order in the absence of a DNR order, or by writing orders to perform certain ACLS-related interventions in a patient with a DNR order.

    a) A Limited Treatment order not to transfuse blood might be requested for religious reasons by a patient who otherwise desires CPR. In fact, CPR may be medically indicated and potentially beneficial to this patient as long as the cardiopulmonary arrest did not result from failure to transfuse blood.

    b) A monitored patient at risk for primary ventricular fibrillation might decline chest compressions and intubation, but agree to attempted defibrillation. To accommodate this situation, a DNR order can be written along with an order to attempt defibrillation for cardiac arrest. Such interventions should only be provided in a monitored setting, and can generally be provided without activating the Code Team.

9. DNR and Limited Treatment orders should be discussed with and agreed upon by the patient and/or surrogate decision maker(s) in the context of the patient's overall care and treatment goals. DNR and Limited Treatment orders may be appropriate in a variety of clinical situations and may be compatible with aggressive and intensive medical care or participation in research. DNR and Limited Treatment orders do not preclude admission to the ICUs and allow initiation of treatments or interventions, other than those specified. Decisions about medical interventions not specified should be made independently.

C. Procedural Guidelines

1. Indications for considering and possibly beginning the DNR/Limited Treatment order process:

a) The patient expresses a preference to forego CPR.

b) The patient is considered to be terminally ill.

c) The burden of resuscitation, from the perspective of the patient or surrogate, outweighs its potential benefit.

d) The patient's life would be marked by suffering or would be so limited in its opportunities that the patient would prefer not to survive a cardiopulmonary arrest resuscitation. Quality of life decisions should reflect the patient's perception of "quality of life."

e) There is no medical benefit to CPR. "No medical benefit" means that CPR has no reasonable likelihood of success.

f) CPR is considered inappropriate because of a terminal, irreversible illness where death is expected and imminent (within 2 weeks).

2. Discussion

a) Decisions regarding DNR and Limited Treatment orders for a patient or research subject with decision-making capacity must actively involve that individual.

b) For adults without decision-making capacity or for minors, legal guardians or other surrogate decision makers (either appointed by a durable power of attorney for health care or legally recognized by the law of the State of Maryland) should actively participate in any decision regarding DNR and Limited Treatment orders.

c) The CC encourages the inclusion of children in discussions regarding their treatment and participation in research. Psychiatric and pediatric resources are available to assist in discussions with children regarding quality of life issues and desires for continued treatment. DNR and Limited Treatment orders should reflect the wishes of minors and their guardians.

d) The patient's preferences as expressed in an advance directive should be honored. However, a written advance directive not to be resuscitated does not preclude the need for a discussion with the patient or surrogate, proper documentation, and the writing of the DNR order.

e) The discussion of DNR and Limited Treatment orders should be presented in a manner that is understandable to the patient and/or the surrogate and include:

(1) a description of CPR and its goals, and/or a description of any other interventions that could or could not be initiated.

(2) the likelihood of success and possible outcomes.

(3) the physician's recommendation.

(4) active solicitation of patient preferences.

f) Emergency DNR Orders

(1) If a patient has a cardiopulmonary arrest prior to the writing of a DNR order, but has a known advance directive not to be resuscitated, then a verbal DNR order should be given by the physician in attendance and documented.

(2) If a patient has a cardiopulmonary arrest prior to an informed DNR discussion/decision

and the responsible physicians are present and consider CPR to provide no medical benefit (see C.1.e for definition), then a verbal DNR order can be given and documented. However, every possible effort should be made to have an informed DNR decision obtained in a compassionate and timely manner in order to avoid this situation.

3. Disagreements

a) Interventions with no medical benefit should not be recommended or imposed upon a patient.

b) It is recognized that a consensus regarding DNR and Limited Treatment orders may not exist among patients or surrogates and the responsible attending physician.

c) All DNR order requests by patients with decision-making capacity will be honored. However, some protocols, treatments and procedures may not be considered medically appropriate for patients with active DNR orders (see C.5). Therefore, it may be necessary to forego the protocol, treatment or procedure.

(1) If the patient or surrogate disagrees with the medical decision to forego a treatment or procedure, the Department of Clinical Bioethics can be consulted.

(2) If the disagreement cannot be satisfactorily resolved, transfer of the patient to another physician or facility willing to provide the treatment or procedure should be considered.

(3) The process followed and the decisions reached should be documented in the patient's chart.

d) Intervention in the case of a cardiopulmonary arrest is inappropriate for some patients,

particularly those with terminal, irreversible illness whose death is expected and imminent (within 2 weeks). If the attending physician believes that it is medically or ethically unacceptable to provide resuscitation, and this determination is contrary to the preferences of the patient or surrogate, the following procedure should be initiated:

(1) Consult another attending physician to assess the decision.

(2) Consult the Department of Clinical Bioethics for assistance in resolving the disagreement. Advice from the Office of the General Counsel of NIH should be obtained if necessary.

(3) If it is the opinion of the attending physician that the patient's decision might have been unduly affected by a neuropsychiatric condition that impairs decision-making capacity (e.g. psychosis, depression, anxiety, organic brain disease), psychiatry and/or neurology consultation should be considered.

(4) If a resolution is not reached, the physician should make a reasonable attempt to transfer the patient to another physician or facility willing to abide by the patient's or surrogate's wishes.

(5) If transfer is not possible, and a consensus exists among the physicians and medical staff caring for the patient and the Clinical Bioethics consultant that CPR attempts would be medically or ethically unacceptable, then a decision can be made to withhold CPR over the patient's or surrogate's objections. This decision, the reason for it, and the process followed must be documented in the patient's chart. The patient or surrogate must be fully informed of the decision and of the management plan that will be followed.

e) A decision to write a DNR order with or without a Limited Treatment order, even with patient or surrogate agreement, should represent a considered consensus of the health care team caring for the patient. Disagreements among staff should be addressed. If a resolution is not reached by team members, consultation with the Department of Clinical Bioethics should be considered.

4. Documentation

a) DNR and Limited Treatment orders must be entered into the MIS (Medical Information System) for inpatients and outpatients consistent with the following:

(1) Do not write orders instructing the Code Team to conduct partial or limited codes. (see B.6 and B.7).

(2) A DNR order does not necessarily preclude orders for ACLS-related interventions. Providing these limited interventions is not a function of the Code Team (B.9).

(3) Do not write Limited Treatment orders that could limit standard CPR or ACLS practices (in the absence of a DNR order) or otherwise lead to medically inconsistent care or unintended outcomes (see B.7, B.8 and B.9).

(4) A Limited Treatment order should specify both the restricted intervention and the situation in which it is not to be initiated (e.g., “Do not start vasopressor therapy for hypotension”).

b) A physician note shall be placed in the patient chart at the time a DNR or Limited Treatment order is written that includes information concerning:

(1) Patient’s decision-making capacity, medical condition, and prognosis.

(2) Reason (indication) for the DNR and/or Limited Treatment orders.

(3) Discussion with other consultants, if this took place.

(4) Details of discussion with patient or surrogate decision-maker, noting specifically everyone who participated in the discussion (other family members and/or significant other), the content of the discussion, and the final decision.

c) In general, DNR or Limited Treatment orders and the accompanying note in the patient chart should be written by an attending physician responsible for the patient. When this is not possible, the order and required documentation can be written by a licensed Medical Staff Fellow, but only after direct telephone consultation with and approval by the attending physician. The attending physician must then review the decision and documentation and co-sign the note within 24 hours of the order.

d) The decision not to attempt resuscitation must be communicated to all appropriate medical and nursing staff. This includes application of the designated DNR sticker to the front cover of the patient's chart.

5. Re-evaluation

a) For any procedure with a known risk of cardiopulmonary arrest (e.g., surgery requiring general anesthesia or angiography), the propriety of all active DNR and Limited Treatment orders will be re-evaluated and discussed with the patient or his/her surrogate and documented in the medical record by the physician obtaining informed consent.

(1) In general, DNR and Limited Treatment orders should be temporarily rescinded prior to

attempting these procedures, provided that the patient or surrogate agrees. Discussions should be guided by the patient's preferences and the overall goals of treatment and may consider the following:

(a) Certain procedures (such as general anesthesia) may induce an artificial state of pulmonary arrest or cardiac arrest that are not intended to be governed by a DNR order.

(b) Other procedures have recognized iatrogenic complications that may precipitate cardiopulmonary arrest, but are often reversible and have a good prognosis when properly treated. Examples include anaphylactic reactions to radiographic contrast and arrhythmias induced by central line insertion.

(2) DNR and Limited Treatment orders can remain in force when so requested by the patient or his/her surrogate, if the physician performing the procedure is willing to proceed.

(3) Disagreements should be addressed as described in Section C.3. In rare instances it may be necessary to forego the procedure.

b) The DNR order should be reviewed any time there are significant changes in the patient's condition or treatment circumstances, at the patient's or surrogate's request, or periodically as required by procedures of the patient care unit.

c) When the patient is discharged from the Clinical Center, the DNR order must be noted in the final written progress note and discharge summary. When a patient is discharged to the outpatient clinic at the Clinical Center, the DNR order will remain in

effect, unless rescinded for other reasons. Patients previously discharged from the Clinical Center with a DNR order must be reassessed upon all subsequent readmissions. If indicated, a new DNR order must be written.